US Family Health Plan
Prior Authorization Request Form for
dimethyl fumarate (Tecfidera)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1

Please complete patient and physician information (please print):

Patient Name:	______________	Physician Name:	______________
Address:	______________	Address:	______________
	______________		______________
Sponsor ID #	______________	Phone #:	______________
Date of Birth:		Secure Fax #:	

Step 2

Please complete the clinical assessment:

Question		
1. **Does the patient have a documented diagnosis of a relapsing form of multiple sclerosis (MS)?**	☐ Yes Proceed to question 2	☐ No Coverage not approved
2. **Has a CBC (complete blood count) been obtained within 6 months prior to initiation of therapy, due to risk of lymphopenia?**	☐ Yes Proceed to question 3	☐ No Coverage not approved
3. **Will dimethyl fumarate (Tecfidera) be used concomitantly with other disease-modifying drugs used in the treatment of MS (multiple sclerosis)** (for example, Aubagio, Avonex, Betaseron, Copaxone, Extavia, Gilenya, Novantrone, Rebif, Tysabri) **?**	☐ Yes Coverage not approved	☐ No Sign and date below

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_______________________________ ____________

Prescriber Signature Date

[22 Jan 2014]